United States Court of Appeals

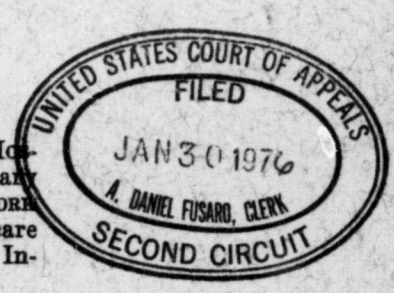
for the Second Circuit

APPELLANT'S REPLY BRIEF

75-6128

United States Court of Appeals

FOR THE SECOND CIRCUIT



GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs-Appellants,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs-Appellants,

—against—

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants-Respondents.

B P/S

REPLY BRIEF OF PLAINTIFFS-APPELLANTS

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GREATER NEW YORK HOSPITAL ASSOCIATION and PENNINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary non-profit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

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REPLY BRIEF OF PLAINTIFFS-APPELLANTS

ARGUMENT

POINT I

APPELLEES' BRIEF FAILS TO ESTABLISH THAT THE ACTION OF HEW IS THAT RARE EXCEPTION WHICH IS EXEMPT FROM JUDICIAL REVIEW.

Essentially, appellees' claim that the promulgation of the New PIP regulation is not judicially reviewable because there are no standards by which a court can evaluate the Secretary's adoption of the regulation. According to the government,"the language 'as the Secretary believes appropriate' is completely open-ended." and, thus, unreviewable by any court. (Appellees' brief, p. 10) This is, of course, a totally erroneous view of the law. It is plain that the Secretary's action must be evaluated in light of the overall purpose of the Medicare Act as well as that statute's provisions which mandate the payment of the reasonable cost of services and prohibit the shifting of the costs of rendering services to Medicare beneficiaries to non-Medicare beneficiaries. 42 U.S.C. §§1395f(b), 1395x(v)(1)(A).

That these are the appropriate considerations is apparent from the opinion in Barlow v. Collins, 397 U.S. 159 (1970) which held that the grant to the Secretary of Agriculture of

> the authority to promulgate such regulations "as he may deem proper" Id. at 165-166,

did not preclude judicial review under the exception to judicial review in the Administrative Procedure Act for

"agency action [which] is committed to agency discretion by law." 5 U.S.C. §701(a)(2). Id. at 165-166. In reaching its conclusion, the Supreme Court relied heavily on both congressional intent and a broadly expressed purpose in the Food and Agriculture Act of 1965 that the Secretary protect the interests of tenant farmers. Id. at 164-165.

Congress has demonstrated its intent that hospital and related services of the highest quality and reasonable cost be provided under the Medicare program (U.S. Code Congressional and Administrative News, 89th Congress, 1st Sess., 1965 (1965) 42 U.S.C. §1395f), and has expressly directed that the Secretary only establish regulations which are "necessary to the efficient administration" of his functions under this program. 42 U.S.C. §1302. If hospitals are forced to increase their costs or curtail services, as they will be under the New PIP system (147a, 150a), neither of these objectives can be achieved.

Appellees maintain that Barlow is distinguishable from the instant case because

> the regulation there was challenged on the ground that its definition of the phrase "making a crop" conflicted with the definition of that term intended by the statute. (Appellees' brief p. 12).

What appellees fail to mention, is that because there was nothing in the statute itself on this point, the only

standard which the Court could have used in reviewing the agency's definition of "making a crop" was congressional intent and the broad statutory purpose of protecting tenant farmers. That this is what in fact occurred is clear from the Court's opinion which only refers to these two criteria. In the instant case, the Court is being asked to determine what is meant by the word "appropriate" in 42 U.S.C. §1395g in light of the purpose and language of the Medicare Act.

Appellees base the greater part of their argument regarding the nonreviewability of the New PIP regulation on Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971). (Appellees' brief, Point I). They claim that under Overton, consideration of legislative intent is not proper. (Appellees' brief, footnote p. 9). The language in that case quite clearly refutes this position:

> [B]ecause of this ambiguity it is clear that we must look primarily to the statutes themselves to find the legislative intent. Overton, supra, at 412 footnote 29.

They also argue that even though the District Court found

> no clear and convincing showing of legislative intent to prohibit judicial review (318a)

Overton, nevertheless, mandates the denial of review under

the exception for agency action "committed to agency discretion by law." (Appellees' brief, p. 13) We have demonstrated in Point I of our main brief why this exception should not apply in the absence of clear legislative intent when the statute under which review is sought is silent on review ability. At least two different circuit courts have adopted this interpretation of Overton. Parker v. United States, 448 F.2d 793, 795 (10th Cir. 1971), cert. den. 405 U.S. 989 and Rockbridge v. Lincoln, 449 F.2d 567, 570 (9th Cir. 1971). In Parker the Court stated:

> [A]dministrative decisions such as the one here considered are subject to judicial review under the Administrative Procedure Act, 5 U.S.C. §701, unless specifically prohibited by the Congress or falling within the "narrow exception" of agency action committed to the wide discretion of the administrative body by law as evidenced by clear congressional intent. Citizens to Preserve Overton Park, supra, at 410, 91 S.Ct. 814. Id. at 795 (emphasis supplied).

In further support of their position that the repeal of the Old PIP reimbursement system is nonreviewable, appellees cite two cases: East Oakland-Fruitvale Planning Council v. Rumsfeld, 471 F.2d 524 (9th Cir. 1972) and Kletschka v. Driver, 411 F.2d 436 (2d Cir. 1969). Both of these cases are clearly inapposite. Contrary to the impression given in appellees' brief, the court in East Oakland found that the local OEO director's action sustaining a governor's veto of

a local OEO program was reviewable for the purpose of determining whether it was made on a "ground wholly unrelated to the merits of the vetoed project." 471 F.2d at 534. In reaching this determination, the Court relied heavily on the congressional intent that this factor be considered.* Thus, this case offers further support for appellants' position -- that the legislative intent behind a statute such as the Medicare Act must be examined by the Court in any determination of reviewability. The Court in East Oakland also found that

> [t]he burden imposed upon the Director and the courts by judicial review of the separable issue would be slight, and the rejected applicant's need for review is great. Id. at 535, footnote 13.

Similarly, in the present case, the hospitals' need for review is great while the burden on HEW would be slight.

Kletschka is also inapplicable to the present facts. This case involved the question of reviewability of the withdrawal of a medical research grant and transfer of a doctor from assignment at one Veterans Administration hospital to another. The Court based its denial of review on the fact that the agency's determination involved an analysis of complex scientific data and the

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* In its discussion of reviewability, the Court cites its earlier decision in Rockbridge, supra. East Oakland, supra, at 532, 533.

facts surrounding an employee's personnel relations. In the instant case, we are dealing not with complex technical questions or the terms of employment of an individual, but the economic viability of an entire industry which is vital to the health and welfare of the City of New York.

The basic philosophy running throughout appellees' brief is that the authority granted the Secretary pursuant to 42 U.S.C. §1395g is unlimited and can be exercised by him without the slightest regard to the effect which his actions may have on the public welfare. (Appellees' brief, p. 10). As we have shown in Point I of our main brief, the "discretion" exception can not shield an agency's abuse of discretion.

> The problem illustrated by appellee's apparent misconception of the nature of issues reserved to agency discretion is resolved by a careful reading of the various parts of section 10 of the Administrative Procedure Act; while review is not granted for action "by law committed to agency discretion," as noted in section 701(a)(2), review is expressly provided for when there is an abuse of that discretion.... Scanwell Laboratories, Inc. v. Shaffer, 424 F.2d 859, 874 (D.C. Cir. 1970).

The uncontradicted proof establishes that the implementation of the New PIP system will cost the hospitals a permanent loss of working capital in excess of $34 million*(279a - 281a) and result in the loss of vital health services to the

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* This figure includes the loss of cash flow to the intervenor hospitals.

citizens of New York (147a, 150a). Government action which produces such consequences must be reviewable. As one commentator has stated:

> Overton Park represents the Court's expansion of judicial review of agency decisions. It is submitted that this expansion is a wise one. Legitimacy of administrative action is grounded on the premise that it is an expression of popular consent through a legislative delegation. "[A]vailability of judicial review is the necessary condition ... of a system of administrative power which purports to be legitimate, or legally valid." If the courts do not assure that the legislative intent - i.e., law to apply - is followed, the delegation of power to administrators will be a delegation to act illegally. Such is not consistent with the notions of government by the governed, nor a system of laws and not men. 1972 Wis. L. Rev. 626 (1972)

POINT II

THE REGULATION REPEALING THE OLD PIP MEDICARE REIMBURSEMENT SYSTEM IS ARBITRARY, CAPRICIOUS AND AN ABUSE OF DISCRETION.

In arguing that the repeal of the Old PIP regulation was neither arbitrary, capricious nor an abuse of discretion, appellees overlook a basic principle which is applicable here, i.e., whether the reasons offered by an agency for action which it has taken are supported by the administrative record in existence at the time the challenged regulation was promulgated. Camp v. Pitts, 411 U.S. 138, 142 (1973); Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 419 (1971); Securities and Exchange Commission v. Chenery Corp., 318 U.S. 80, 87, 93-94 (1943). In Camp v. Pitts, the Supreme Court said:

> The appropriate standard for review was, accordingly, whether the Comptroller's adjudication was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," as specified in 5 U.S.C. §706(2)(A). In applying that standard, the focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court.

We emphasize here that of all the reasons advanced by Jansak, the Government's witness, for the change in the regulation, the only one which is supported by the record in the agency at the time it promulgated the new PIP regulation, was that the new system would be more consistent with traditional billing than the existing one (275a).

To be sure, a court should not substitute its judgment for agency expertise, but this does not eliminate the agency's obligation to have an administrative record which supports its action. Camp v. Pitts, 411 U.S. 138 (1973); Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 415 (1971).

If, after examining the administrative record, the Court finds inadequate support for the action taken by the agency, it should invalidate the regulation and remand the matter to the agency for further consideration. Camp v. Pitts, supra, at 143; Securities and Exchange Commission v. Chenery Corp., supra, at 95; National Nutritional Foods Association v. Weinberger, 513 F.2d 6[illegible], 701 (2d Cir. 1975).

Appellees' brief ignores these principles. This is especially apparent from their misinterpretation of the language in Consumers Union of United States v. Consumer Products Safety Commission, 491 F2d 810 (2d Cir. 1974) that "it is sufficient that the regulations be supported by evidence in the Commission's files, or even by its experience." Id. at 812 (Appellees' brief, p. 25). In National Nutritional Foods Association v. Weinberger, supra, this Court made clear that "the agency's experience, to the extent that it provides a factual basis for a regulation under attack, must be a matter

of record in order to qualify for consideration by a reviewing court." Id. at 701, footnote 11. (emphasis in original) This explanation by the Court was made with specific reference to the Consumers Union case.

In the instant case, two of the three reasons given by the government in support of the New PIP regulation - that Old PIP paid the hospitals before they were required to pay their employees and vendors and that Old PIP was creating a drain on the Federal Hospital Insurance Trust Fund - were offered for the first time during the hearing in the District Court (207a). While such "post hoc" rationalizations are permissible for the purpose of identifying the reasons behind agency action, they cannot, in and of themselves, constitute an administrative record sufficient for judicial review. Citizens to Preserve Overton Park, Inc. v. Volpe, supra, at 825; Burlington Truck Lines, Inc. v. United States, 371 U.S. 156, 168-169 (1962).

(i) The Government's Claim That The Old PIP System Creates a Drain on The Federal Hospital Insurance Trust Fund is Frivolous.

The government's claim that one of the reasons why the Secretary promulgated the New PIP regulation was because the Old PIP regulation created an unnecessary drain on the Federal Hospital Insurance Trust Fund is frivolous. The

Federal Hospital Insurance Fund is established under 42 U.S.C. §1395i and consists of the moneys collected by the Treasury from the taxes imposed under Sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 as well as the taxes imposed by section 1401(b) of the Internal Revenue Code. These taxes are imposed with respect to wages and self-employment income.

Section 1395i(c) directs the Managing Trustee of the Board of Trustees of the Trust Fund to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. "Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States."

Thus, it is apparent that the government's argument that under the Old PIP system "the Government was losing interest on those funds, and that Old PIP therefore created a drain on the Medicare Hospital Trust Fund" (sic) (207a) (Appellees' brief p. 26) is nonsense. The trust fund is a government fund and the interest which it earns comes from government obligations. Thus, the government makes a paper transfer of credits from one "Fund" to another "Fund." This is like an individual transferring money from one pocket to another. There is no real gain or loss of moneys whether or not under these circumstances there are more or less dollars credited to the Trust Fund at any particular moment.

On the other hand, there is a real loss to the hospitals in this case when the Government deliberately deprives them of more than $34,000,000 in cash flow. When that occurs, hospitals which are able to do so must borrow money and pay interest to banks for the use of the borrowed funds. The payment of this interest increases the hospital's cost of operations and to the extent that a portion thereof is borne by Medicare this really increases the government's expense.

The inflationary impact of these unnecessary costs and the loss to the public, particularly the aged and the indigent, when voluntary hospitals which cannot borrow are forced to eliminate needed services, are the sad results of this misguided policy.

(ii) The Hospitals Are Entitled To Be Paid Promptly After They Render Services To Medicare Patients.

In our main brief, we pointed out that it was not at all unreasonable for the hospitals to ask the Government to pay them for services rendered to Medicare patients promptly after the services are rendered. (Appellants' brief, p. 38). Thus, we pointed out that in view of the hospitals' shortage of working capital, the Old PIP system which reimbursed them approximately 3-1/2 days after the services were rendered to patients was reasonable while the New PIP system which

contemplates that the hospitals would be paid about 3 weeks after the services are rendered was totally unreasonable and created extraordinary financial hardships.

The government's brief surprisingly claims that we have misconceived "... the nature of the whole Medicare reimbursement system, for payments are made not for services furnished by the hospital to Medicare patients, but rather for costs 'actually incurred' by the hospitals. 42 U.S.C. §1395x(v)(1)(A)." (Appellees' brief pp. 28-29).

This argument is plainly a distortion of the Medicare system and the hospitals' function. There can be no doubt that the hospitals are reimbursed for health services which they render to patients and they are not being paid for some abstraction entitled costs "actually incurred" during the course of their operation.

In addition to ordinary common sense which ought to indicate what the hospitals are being paid for, the Medicare Act, itself, 42 U.S.C. §1395 et seq., provides in part as follows:

> ... (b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1395e of this title, be -
>
> (1) the lesser of (A) the reasonable

> cost of such services, as determined under section 1395x(v) of this title, or (B) the customary charges with respect to such services; or ... (emphasis supplied).

Section 1395g of the Medicare Act is entitled "Payment to Providers of Services." That section states:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, ... (emphasis supplied).

The government's contention in this respect is either cynical or entirely frivolous for it is hard to believe that a good faith argument can be made that the hospitals are being reimbursed under the Medicare Act for something other than health services actually rendered to patients.

Once this is established, it is clear that, in the face of the hospitals' deplorable financial condition, it is unreasonable, arbitrary and capricious for the Secretary to insist that they be paid under the New PIP system with its ruinous consequences rather than under the old system which has been in existence for almost eight years. This is particularly true when analysis demonstrates that there is no commensurate benefit to the government.

Finally, we note that the major portion of the appellees' discussion on the "arbitrary and capricious"

point is an attempt to find support in Jansak's testimony for the reasons offered by Jansak as the basis for the New PIP regulation. This is plainly a boot-strap operation. In any event, having anticipated all of these arguments in our main brief (see pp. 36-40), no further discussion of them is warranted here.

POINT III

THE PROPOSED APPLICATION OF THE NEW PIP REIMBURSEMENT REGULATION TO THE CLASS WILL VIOLATE THE MEDICARE ACT AND REGULATIONS

In Point II of our main brief, we demonstrated that the New PIP regulation contravenes the statutory obligations imposed upon the Secretary by the Medicare Act and regulations, i.e., that he reimburse providers the reasonable cost of the services which they render, 42 U.S.C. §§ 1395f(b), 1395x (v)(1)(A); 20 C.F.R. §§ 405.401, 405.402, 405.451, 405.454, and that he insure that the costs of rendering services to Medicare beneficiaries not be shifted to non-Medicare beneficiaries, 42 U.S.C. § 1395x(v)(1)(A); 20 C.F.R. §§ 405.402, 405.403, 405.405, 405.451(b). Here we deal with two of the arguments advanced by the government in refutation.

Appellees contend that it is impossible to ascertain at the present time whether or not HEW will reimburse the hospitals the full cost of borrowing incurred in their conversion to the New PIP system and that therefore the court should not consider the question of whether or not the New PIP regulation will violate the prohibition against the shifting of Medicare costs to non-Medicare beneficiaries. (Appellees' brief, pp. 21-22) This argument flies in the face of reality. As we have pointed out earlier, both the existing Medicare regulations and Jansak's testimony as to

their meaning make it absolutely clear that the hospitals will not be reimbursed the full cost of their borrowing. (221a - 223a). In addition, the appellees' position assumes that each of the members of the Class will in fact be able to borrow the funds necessary to convert to the New PIP system. The testimony at the hearing shows that a number of the hospitals will be unable to do so and will, in fact, have no other option but to curtail vital health services (95a, 101a, 147a, 150a, 169a).

In a similar case, American Hospital Association v. Weinberger, CCH Medicare and Medicaid Guide, ¶27,449 (D.C. Cir. 1975), HEW also argued that its promulgation of a regulation which would have affected hospital Medicare reimbursement was not judicially reviewable because the agency had not rendered a final determination as to the amount of reimbursement which would have been available to each of the individual hospitals affected. That case involved the promulgation of a regulation which would have repealed the 8-1/2% inpatient routine nursing salary cost differential (20 C.F.R. §405.430) as an element of Medicare reimbursement. In granting summary judgment for the plaintiff hospital associations, the District Court rejected the agency's contention that the regulation was not reviewable.

Respondents' reliance upon Abbott Laboratories v.

Gardner, 387 U.S. 136 (1967) and Gardner v. Toilet Goods Association, Inc., 387 U.S. 167 (1967) is, likewise, misplaced. The facts here plainly meet the standards for reviewability enunciated by the Supreme Court in those decisions. It is apparent from the record in this case that the hospitals are faced with a clearly formulated administrative decision which will have an immediate impact upon their financial viability.

> We agree with the Court of Appeals that respondents' challenge to thse regulations is ripe for judicial review under the standards elaborated in Abbott Laboratories v. Gardner, supra, namely the appropriateness of the issues for judicial determination and the immediate severity of the regulations' impact upon the plaintiffs. Id. at 170.

Appellees stubbornly insist that the New PIP regulation will not violate the prohibition against the shifting of Medicare costs to non-Medicare beneficiaries since any interest expense incurred by the hospitals as a result of conversion to the new system would relate to the delivering of services to both Medicare and non-Medicare patients. (Appellees' brief, pp. 22-24) Apart from the fact that this reasoning overlooks the fact that a hospital must be run as a single operating entity, it also ignores the point that was made repeatedly by Judge Metzner in the

hearing below:

> This loan is being caused by your [Medicare's] action and nobody else's. (243a)
>
> ...
>
> Why should they pass it [interest cost] on if you caused it? Why couldn't you pay for what you caused? That is what the case is all about (163a).

CONCLUSION

For the reasons stated above, the Order of the District Court dismissing the complaint should be reversed.

Respectfully submitted,

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Service of ~~three~~ Two (2) copies of the within Reply Brief
is admitted this 30th day of January 1976

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